Medi-Cal Redesign Stakeholder Process

Medi-Cal Mental Health Program

Background

California established its Medicaid program, called Medi-Cal, in 1966. The specialty mental health services reimbursed by this program included psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists. In 1971, legislation in California added Short-Doyle community mental health services to the scope of benefits of the Medi-Cal program for the first time. This change enabled counties to obtain federal matching funds for their costs of providing Short-Doyle community mental health services to persons eligible for Medi-Cal. At this point the Medi-Cal program was split into two mental health delivery systems. The original program continued as the Fee-for-Service/Medi-Cal (FFS/MC) system; the counties became the providers of a new benefit, Short-Doyle/Medi-Cal (SD/MC) services. SD/MC services included many of the services provided by the Short-Doyle program, but not all. Socialization and vocational programs, for instance, were not covered. The SD/MC program provided a much broader range of mental health services, using a wider group of service delivery personnel, than were offered under FFS/MC.

A Medicaid State Plan Amendment implemented in October 1989 added targeted case management to the scope of benefits offered under the SD/MC system. Another State Plan Amendment, implemented in July 1993, added services available under the Rehabilitation Option to the SD/MC scope of benefits and broadened the range of personnel who could provide services and the locations at which services could be delivered.

Based on approval of a Section 1915(b) waiver effective March 17, 1995, California consolidated FFS/MC and SD/MC psychiatric inpatient hospital services at the county level. County mental health departments became responsible for both FFS/MC and SD/MC psychiatric inpatient hospital systems for the first time. A separate Section 1915(b) waiver was also approved for the Medi-Cal Mental Health Care Field Test in San Mateo County in 1995.

In 1997, California requested a renewal, modification and renaming of the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver program to include both inpatient hospital and professional specialty mental

health services under the responsibility of a single mental health plan (MHP) in each county. The renewed waiver, called Medi-Cal Specialty Mental Health Services Consolidation, was approved by CMS on September 5, 1997.

Implementation of the renewed waiver, referred to as “Phase II" implementation, occurred at various times in each California county between November 1, 1997, and July 1, 1998, depending on the readiness of the MHP in each county. During the first waiver renewal period, MHPs became responsible for authorization and payment of professional specialty mental health services that were previously reimbursed through the FFS/MC claiming system. At that time, both inpatient hospital and professional Medi-Cal specialty mental health services previously reimbursed through FFS/MC and SD/MC claiming systems became the responsibility of a single entity, the MHP, in each county.

Core Principles and Aims of the Medi-Cal Managed Mental Health Care System

California has adapted the six aims elaborated in the Institute of Medicine’s 2001 Quality Chasm report in developing the following core principles and aims for the Medi-Cal Managed Mental Health Care System.

1. Safety - An emotionally and physically safe, compassionate, trusting and caring treatment/working environment is provided for all clients, family members and staff.
2. Effectiveness - Up-to-date, contemporary and culturally/ethnically inclusive evidence-based services are provided in response to and respectful of individual choice and preference.
3. Person and Family Centered - Service provision is guided by a highly individualized comprehensive approach to understanding each individual’s and family’s history, strengths, needs and vision of their own recovery including attention to the issues of culture, spirituality, trauma, and other factors that impact service plans and outcomes, which are built upon respect for the dignity of each person.
4. Timeliness - Prompt provision of goal-directed services restores and sustains client and family integration into the community.
5. Efficiency
Administrative and clinical operations manage human and physical resources in ways that optimize access to appropriate treatment and minimize waste.
6. Equitable

Fair, culturally, and linguistically competent care is provided to all individuals and
families regardless of their race, ethnicity, age, gender, religion, sexual orientation, disability, and legal status.

Medi-Cal Mental Health Re-Design Stakeholder Process

Governor Schwarzenegger, in his proposed budget for FY 2004/05, announced his intention to seek federal approval to redesign Medi-Cal in order to contain costs while avoiding deep cuts in eligibility benefits. As part of the redesign process, the California Health and Human Services Agency sought stakeholder input on the State's proposed changes and suggestions for new ideas for the program. For specialty mental health services provided under the Medi-Cal Managed Care Program, the Department of Mental Health carried out an additional stakeholder input process focused upon developing strategies for specialty mental health services.

In addition to specific strategies, there were some overall concepts and concerns that emerged from stakeholders.

- Stakeholders stressed the importance of culturally competent services.
- Stakeholders affirmed and encouraged an emphasis on practices that have been proven to be effective especially those that have been validated scientifically. Adult services are based on a client and family centered vision of recovery. Services for children and youth are family focused, flexible, and age appropriate with interagency coordination. It was recognized that a significant investment in training is required to achieve these goals.
- Concern was expressed about any actions which would serve to "cap" Federal Medicaid funding for mental health services.
- Participants advocated for a renewed focus on preventive services.
- There was a belief that there remain unmet needs in providing services to children/youth with emotional disturbance. Concern was expressed about reducing access to mental health services for youth under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- Stakeholders advocated providing services based on individual needs rather than aid code.
- Although Medi-Cal Mental Health Plans do not have responsibility for pharmacy, concerns were expressed about any changes that might limit access to psychotropic medications.

What follows is an analysis of the major redesign strategies raised in the stakeholder process, including client and family impacts/concerns, programmatic impacts and fiscal impacts on federal, state and local MHP resources. The overall concepts and concerns described above are not repeated in the analysis. Most of the specific strategies suggested can be done within the existing Medicaid State Plan and the 1915(b) waiver. The analysis is divided into a section that specifically impacts youth services and a second section that covers more general suggestions.

DMH Stakeholder Process
Analysis of Stakeholder Suggestions for Medi-Cal Redesign

Note: There is some overlap between issues of concern for client and family members and programmatic or fiscal impact columns

Children and Youth

Suggestion	Programmatic Impact	Client and Family Member Impact/Concerns	Fiscal Impact on Specialty Mental Health Medi-Cal		
			Federal	**State**	**MHP**
1. Make AB 3632 youth eligible for Medi-Cal	1. Would require a Home and Community Based waiver to expand Medi-Cal eligibility. Youth would have to qualify for an institutional level of care (i.e. a hospital, nursing facility or interm. care facility for persons with mental retardation) in order to be eligible.	1. Would create Medi-Cal eligibility for some youth who qualify as needing institutional care 2. Further study is indicated as it is unclear what the consequences of a home and community based waiver would be and whether this would actually result in additional funding	Waiver has to be cost neutral—that is, the total amount of FFP can be no more than would exist without the waiver. All health care costs, not just mental health care would have	1. Could increase SGF under EPSDT. Could decrease state mandate funding 2. Additional state staffing needed to analyze, develop and implement waiver.	Could increase MHP share of EPSDT growth

	2. It could expand the range of services that would be eligible for reimbursement, as long as the services were necessary to avoid institutionalization 3. Study is needed to determine what the consequences of a home and community based waiver would be and whether it would result in additional funding and/or services. 4. Could allow for broader range of services for this population 5. May reduce out-of-home placements	and/or services. 3. Could allow for broader range of services for this population 4. May reduce some out- of-home placements	to be included in the waiver and would come under the requirement for cost neutrality The costs for the population being added would previously not have been in the base.		

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2. Capitate EPSDT	1. Would create incentives to limit both access and services by "capping" funding per eligible 2. Would increase program flexibility by eliminating claiming by service, SMA's, settling to cost report, etc. Revenues would be easier to project, and there would be greatly reduced risk of audit disallowances. 3. Would be difficult for small MHPs to	1. Could limit access and/or services 2. Could allow for more flexible program due to change in financial structure	FFP would be dependent on numbers of Medi-Cal eligible youth in each aid code rather than amount of services provided	1. SGF expenditures would be dependent on numbers of Medi-Cal eligible youth in each aid code rather than amount of services provided. 2. Additional state staff needed to determine feasibility, develop, implement and monitor capitation.	MHP share of growth would be dependent on numbers of Medi-Cal eligible youth in each aid code rather than amount of services provided

	continue to exist without some kind of risk pools, risk corridors and/or reinsurance 4. Would require major programmatic and fiscal restructuring. MHPs would need to become more sophisticated in managing access and cost per client since funds would be capped. Both MHP and DMH billing and claiming systems would need to be changed. MHPs would need to report encounter and cost data for waiver purposes, but would not settle to cost under the current cost reporting system.				

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3. Establish Medi-Cal eligibility for youth in the juvenile justice system who are awaiting adjudication	1. This might be possible under existing State Plan and waiver 2. Would enable programs already providing services to these youth to get FFP to maintain or expand services 3. Could encourage MHPs to develop new services for this population	1. Could increase mental health services for this population 2. May encourage increased use of this type of institutional care	Would increase FFP	Could increase SGF if new services are implemented for this population	Could increase MHP share of match for EPSDT growth if new services are implemented for this population

General

Suggestion	Programmatic Impact	Client and Family Member Impact/Concerns	Fiscal Impact on Specialty Mental Health Medi-Cal		
			Federal	**State**	**MHP**
4. Clarify the ability to provide adult peer support services under the Rehab Option and Targeted Case Management or add these services to State Medi-Cal Plan. Services might include self-help support groups, drop-in centers, client-run crises/respite services, clubhouses, telephone support lines, etc.	1. Support existing recovery-oriented services. 2. Redirect other existing services to recovery-oriented services 3. Expand recovery oriented services	1. Since clients would be the providers of these services they need to drive the decisions about obtaining Medi-Cal reimbursement for them 2. Should not be limited to clients at risk of rehospitalization	1. Increase FFP for short term 2. More cost effective services could reduce FFP over the long term	Could require additional state staffing resources to implement	1. Expanded services would require additional local match 2. More cost effective services could reduce local costs over the long term

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5. Add employment services to State Medi-Cal Plan such as vocational assessments, work preparation activities, development of job and career development plans, assistance in locating employment and/or integrated supported employment such as outreach/job coaching, on-the-job support, etc.	1. Support existing employment services 2. Redirect other existing services to employment focused services. Needs further study 3. Expand employment services 4. Some of this can be done under current State Plan	1. Dealing with employment as a mental health issue could put clients at risk of stigma and discrimination 2. Not all clients are able to work	1. Increase FFP for short term 2. More cost effective services could reduce FFP over the long term	Would require additional state staffing resources to implement	1. Expanded services would require additional local match 2. More cost effective services could reduce local costs over the long term

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6. Include coverage for services to adults with substance abuse and mental illness; create the ability to provide integrated treatment to those at highest risk for rehospitalization.	1. Allow dually diagnosed individuals to receive integrated treatment for both disorders 2. Encourage expansion of dually diagnosed services/programs	1. Should not be limited to clients at risk of rehospitalization 2. Could be based on severity of problems	1. Increase FFP for short term 2. More cost effective services could reduce FFP over long term	Could require additional state staffing resources to implement	1. Expanded services would require additional local match. 2. More cost effective services could reduce local costs esp for repeat hosp. over long term

Suggestion	Programmatic Impact	Client and Family Member Impact/Concerns	Fiscal Impact on Specialty Mental Health Medi-Cal		
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7. Replace day treatment intensive and day rehabilitation for adults with partial hospitalization.	1. Focus adult day services on short-term intensive services using a more standardized partial hospitalization model. Simplify administrative work involved with monitoring and claiming FFP. 2. Would involve program changes in some MHPs in order to continue claiming FFP	1. Unclear as to what the impact would be. Requires more analysis. Could have unintended consequences 2. Something is needed that is less intensive than partial hospitalization, but more intensive than outpatient services	Assumption is limited impact on FFP, because resources and services would be redirected to other more effective service delivery models.	Could require additional state staffing resources to implement	Assumption is limited impact on FFP, because resources and services would be redirected to other more effective service delivery models.

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8. Waive IMD exclusion for freestanding psychiatric hospitals and psychiatric health facilities greater than 16 beds serving adults for inpatient services.	1. Could increase number of acute inpatient beds for some MHPs 2. Could result in hospitals closer to home for some MHPs 3. This could create incentives (by virtue of availability) for more hospitalizations and for larger acute institutions that would ultimately lead away from the concepts embodied in the Olmstead decision and the desired emphasis on	1. Could create incentives for more hospitalizations, more involuntary treatment 2. Funding should be for community-based services, not acute facilities 3. May not be compatible with Olmstead concepts	Increased FFP for existing services if hosp. increased.	No impact	1. MHP savings due to the fact that FFP would cover half of what is now a total local cost 2. Could result in lower rates due to increased competition

	less institutional and more community-based services. 4. Could expand/maintain community based services if some federal funds are obtained for facilities that are currently locally funded.				

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9. Flexible financing like the cash and carry or voucher concept	1. Would allow consumers to choose their services and would allow them greater flexibility in managing their care 2. Would cap services an individual could receive during a given time period 3. Could result in less services being available since programs could not plan on a certain amount of revenue to develop service capability	1. Promotes services of choice 2. Mechanics are complex. Needs further study	Would cap FFP per user	Would require additional state staffing resources to determine feasibility, develop and implement	Would cap local county match per user

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10. Eliminate UMDAP requirement for Medi-Cal beneficiaries	Less paperwork				Lower administrative costs
11. Review and streamline administrative requirements	Less administrative work				Reduce administrative costs
12. Obtain exemption from new managed care regulations regarding EQR and informing	1. Less administrative work 2. Some outreach activities could be eliminated	1. Could lose some client protections 2. Staff could focus more on client services rather than new administrative requirements.	Reduce FFP revenues for these activities	Reduce DMH costs, reduce SGF expenditures depending on which provisions are waived	Reduce local administrative costs